

CMS

CENTERS for MEDICARE & MEDICAID SERVICES



Encounter Data Slide Presentations

2011 Regional IT Technical Assistance





2011 Regional IT Technical Assistance Encounter Data



Purpose

- Understand the collection, submission, and processing of encounter data.
- Identify the phases in the transition to the Encounter Data System (EDS).

Technical Assistance Tools

- Encounter Data Participant Guide
- Encounter Data Companion Guide
- PowerPoint Slides
- Job Aids
- Q&A Cards
- Evaluation Form



Practice Example



Select your response to this question.

The next location for the Regional IT TA Sessions should be:

1. Hawaii
2. France
3. Switzerland
4. All of the above

Agenda Topics

Introduction
Overview
Submission
Reports
Compliance
Transition to Encounter Data System
Question and Answer

The session includes two 15 minute breaks and 1:15 minute lunch.

Audience

- Medicare Advantage (MA) Plans
- Medicare Advantage-Prescription Drug Plans (MA-PDs)
- Health Maintenance Organizations (HMOs)
- Special Needs Plans (SNPs)
- Local Preferred Provider Organizations (PPOs)
- Regional PPOs
- Employer Group Health Plans
- Programs for All-Inclusive Care for the Elderly (PACE) Plans
- Cost Plans (1876 Cost HMOs/CMPs and 1833 HCPPs)
- Medical Savings Account Plans
- Private Fee-For-Service Plans
- Religious Fraternal Benefit Plans (RFBs)
- Provider Sponsored Organizations (PSOs)

Technical Assistance and Support



Centers for Medicare & Medicaid

www.cms.gov

Customer Service and Support
Center (CSSC)

www.csscooperations.com

A. Reddix & Associates (ARDX)

EDS@ardx.net
www.tarsc.info



2011 Regional IT Technical Assistance Encounter Data



Purpose

- Provide participants with important terms and key resources.
- Provide participants with implementation schedule information that will provide the foundation for upcoming encounter data training.

Learning Objectives

- Define common encounter data terminology.
- Demonstrate knowledge in interpreting key components of the encounter data process.
- Interpret the encounter data process implementation schedule.
- Identify encounter data outreach efforts available to organizations.

Common Processing System Terms

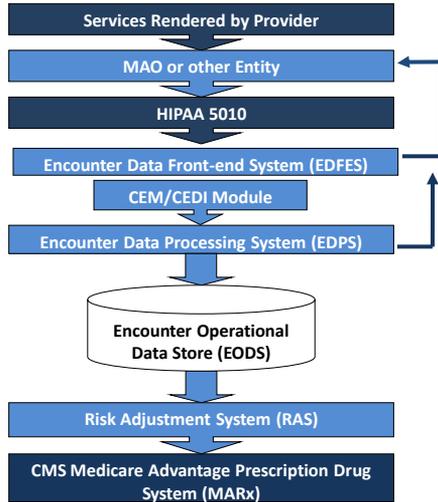
Encounter Data Specific

- Encounter Data Front-End System (EDFES)
 - COTS EDI Translator
 - CEM
 - CEDI
- Encounter Data Processing System (EDPS)
- Encounter Data System (EDS)
- Encounter Operational Data Store (EODS)
- Encounter Data Common Working File (EDCWF)

Existing Processing Systems

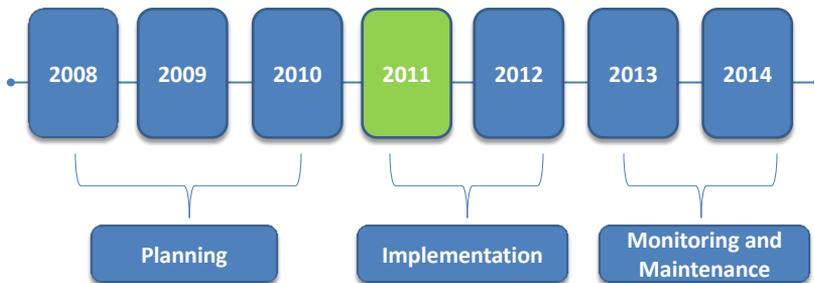
- Fiscal Intermediary Shared System (FISS)
- Multi-Carrier System (MCS)
- ViPS Medicare System (VMS)

Data Flow in the EDS



EDS Implementation Schedule

- The implementation of encounter data will span six (6) years:



Milestones

2008

- IPPS Final Rule clarified CMS' authority to collect encounter data from MAOs and other entities
- CMS obtained support from leadership to develop and implement the system

2009

- Initiate project planning for encounter data and development of Business Process Model
- Synchronization of the EDS with Fee-For-Service (FFS) processing methodology
- Gap analysis for incorporation of the current risk adjustment process with the goals for encounter data implementation

2010

- Completion of Encounter Data Survey of 18 phone interviews of health plans in April 2010
- Established industry outreach program to aid the implementation of encounter data
- Encounter Data National Meeting with 593 attendees in October 2010
- Launched Quarterly Encounter Data Newsletters with information and updates for over 1,800 industry members



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Overview

Milestones (Continued)

2011

- Completion of EDFES Pilot Test in March 2011
- Conducted eight (8) Encounter Data Work Groups with a total of 315 attendees
- Conducted three (3) Industry Updates with 609 attendees and one (1) Encounter Data Call with 258 attendees
- Launched the EDS Inbox to provide communication forum for encounter data questions
- Collaborated with AHIP to identify, address, and create solutions
- Will execute EDFES and EDPS Testing and certification in Fall 2011

2012

- Implementation of the EDS on January 3, 2012 for submission and processing of production encounter data
- Roll-out of encounter data return reports
- Update industry on the quality of encounter data collected and timeline for phase out of RAPS

2013

- Update industry on the quality of encounter data collected and enhancements



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Overview

Encounter Data Implementation Timeline 2011-2012

EVENT	START DATE	END DATE
Test Case Preparation	March 30, 2011	September 05, 2011
Plans Submit Front-End Test Data	September 06, 2011	October 04, 2011
EDPS Test Case Preparation and Education	October 05, 2011	October 28, 2011
Provide Industry with Encounter Data Analytic and Preliminary Error Reports	October 31, 2011	N/A
Execute EDIPPS and EDPPPS End-to-End Testing/Certification	October 31, 2011	November 30, 2011
EDS Roll-out	January 03, 2012	N/A
Roll-out of additional EDS Reports	March 01, 2012	N/A
Industry Status Update on the Quality of Encounter Data collected and Timeline for Shut Down of RAPS	July 01, 2012	N/A

DME Implementation Timeline

EVENT	DATE
MAO and other entity front-end testing of Encounter Data DME CEDI module and EDDPPS begins	February 06, 2012
Roll-out of EDDPPS	May 07, 2012

Training and Support

INITIATIVE	DESCRIPTION
Customer Service & Support Center	Toll free help line (1-877-534-2772) available Monday – Friday 8 A.M. EST – 7 P.M. EST
www.cssoperations.com	CSSC website is the gateway to EDS for information, resources, and training information.
Work Groups and Industry Updates	Conducted as announced to provide information regarding the progress of and updates for encounter data implementation. Register at www.tarsc.info .
www.tarsc.info	Website for encounter data training, work groups, locations, online registration, and encounter data FAQs.
eds@ardx.net	Method for submitting encounter data policy and operational questions during implementation.

Summary

- Defined common encounter data terminology.
- Provided key components of the encounter data process.
- Interpreted the encounter data process implementation schedule.
- Identified encounter data outreach efforts available to organizations.

Evaluation



Please take a moment to complete the evaluation form for the Overview module.

Your Feedback is Important! Thank you!



2011 Regional IT Technical Assistance Encounter Data



Purpose

- Provide data collection and submission principles for encounter data in accordance with CMS requirements.

Learning Objectives

- Describe acceptable sources of data.
- Understand the submission process requirements, connectivity options, and EDS file layout.
- Apply HIPAA transaction standards for purposes of encounter data collection.
- Describe risk adjustment filtering logic.

Sources of Encounter Data

- Encounter data must be collected from these sources:
 - Facility/Institution
 - Professional/Physician Supplier Services
 - DME Supplier
- Encounter data requires the use of a valid NPI.

NPPES

National Provider Identifier

For Health Care Providers
The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique **National Provider Identifier (NPI)**.

Need an NPI?>

[Apply Online for an NPI](#)
Estimated time to complete the NPI application form is 20 minutes.
[Click here to see tips to expedite your NPI application before you begin your application.](#)

Want to View or Update your NPI data?>

[Login](#)

Want to create a Web login for an existing NPI? ---->

[Create Login to View or Update your NPI Data](#)

(This option is only for health care providers previously enumerated via paper or EPI)

Additional Resources:

[NPI Application / Update Form](#) - [\[PDF File\]](#)
[Application Help](#)
[Privacy Information](#)

Note:
The website works best in Internet Explorer versions 6.0 and higher and Firefox versions 2.0 and higher. Users may experience issues with other browsers and are recommended to use the browsers listed above. It is recommended that browser windows be opened using the icon on the desktop to avoid shared browser sessions. Some browsers share sessions regardless of how the browser is opened. Please check with the browser's vendor about session management. When NPPES detects multiple browsers open within the same session, NPPES will terminate the session to protect the data in NPPES. Data entered will be lost and will

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Submission

Inpatient Institutional

ENCOUNTER DATA FACILITY SERVICE	TOB
Inpatient Hospital	11X
Inpatient Rehabilitation Facility	11X
Inpatient Psychiatric Facility	11X
Long-Term Care Hospital	11X
Skilled Nursing Facility Inpatient/Swing Bed	18X, 21X
Critical Access Hospital Inpatient/Swing Bed	11X, 18X
Home Health Facility	32X, 33X

Outpatient Institutional Facility

ENCOUNTER DATA FACILITY SERVICE	TOB
Outpatient Hospital	12X, 13X, 14X
Skilled Nursing Facility Outpatient	22X, 23X
Hospice	81X, 82X
Community Mental Health Center	76X
Home Health Facility	34X
End-Stage Renal Disease Facility	72X
Critical Access Hospital Outpatient	85X
Rural Health Clinic	71X
Federally Qualified Health Center	77X
Outpatient Rehabilitation Facility (CORF/ORF)	74X, 75X
Ambulance	12X, 13X, 22X, 23X, 83X, 85X
Institutional Clinical Laboratory	14X

Professional/Physician Supplier Services

- MAOs and Third Party submitters must collect data from these Professional sources of data:
 - Ambulatory Surgical Centers (ASC)
 - Ambulance
 - Clinical Laboratory Non-Inpatient
 - Physicians/Professionals
 - Durable Medical Equipment (DME)
 - Durable Medical Equipment Supplier

Places of Service (POS)

POS Code	POS Name	POS Definitions
01	Pharmacy	Facility or location where drugs/medically related items/services are sold, dispensed, or provided directly to patients.
03	School	Facility whose primary purpose is education.
04	Homeless Shelter	Facility or location whose primary purpose is to provide temporary housing to homeless individuals.
05	Indian Health Service Free-standing Facility	Facility or location, owned/operated by Indian Health Service, providing diagnostic, therapeutic, and rehabilitation services to American Indians and Alaska Natives, not requiring hospitalization.

*Note: This is not an all inclusive list.

Type of Service (TOS)

TOS Indicator	Descriptor
0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology

*Note: This is not an all inclusive list.

Dental and Vision

Dental Data	Vision Data
<ul style="list-style-type: none">Submitted on the 837-I and 837-P as necessary.All claims meeting the definition of a covered dental service will be priced and stored in the EODS.Non-covered services will be collected on the 837-I or 837-P and stored in the EODS, but will not be priced.	<ul style="list-style-type: none">Submitted on the 837-I or 837-P as necessary.Medicare acceptable vision data will not be priced, but will be stored so EODS can obtain a true picture of MAO's beneficiaries.

Dental Data Example

- Mrs. Smith is admitted into Hope Hospital. While she's in the hospital, she undergoes jaw reconstruction surgery. Hope Hospital submits the claim to Live Well Health Plan.

Question: *How should Live Well Health Plan submit the dental data to the EDS for processing?*

1. Submit an 837-I
2. Submit an 837-P
3. Not acceptable for Encounter Data

Vision Example

- Mrs. Smith underwent cataract surgery and purchased glasses from Dr. Jones. She chooses to purchase the deluxe frame, which is only partially covered by Medicare. Dr. Jones submits the claim to Live Well Health Plan, which identifies the Medicare allowable coverage as well as Mrs. Smith's out-of-pocket expenses for the upgrade to the deluxe frame.

Question: How should this vision service be submitted to EDS?

1. Submit an 837I
2. Submit an 837P
3. Not acceptable for Encounter Data

Submission of DME Provider and Supplier Data

	*DME Provider Data	*DME Supplier Data
Description	DME service incident to a service from a provider.	DME service submitted by a provider considered a supplier for DMEPOS billing.
Translator Module	CEM	CEDI
Processing System	EDIPPS or EDPPPS	EDDPPS

* DME provider and DME supplier data are submitted on separate 837-P files.

DME Example

- Jane needs knee surgery. Dr. Waters provides Jane with crutches prior to the surgery so they will be available following surgery.

Question: How should this DME service be submitted to EDS?

1. Submit an 837-I
2. Submit an 837-P
3. Not acceptable for Encounter Data

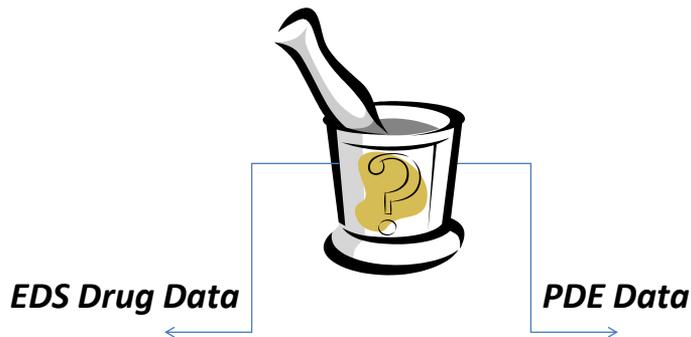
DME Example

- Sally went to MedStore (an approved DME supplier) and purchased a wheelchair on May 27, 2012, which was a Medicare covered service. MedStore sent a claim to HappyHeart Plan (for which Sally is a beneficiary). HappyHeart adjudicates the claim and sends it for encounter data processing.

Question: How should this DME supplier service be submitted to EDS?

1. Submit an 837-I
2. Submit an 837-P
3. Not acceptable for EDS

Pharmacy Data



EDS Drug Data

- Part A
 - Medicare bundled payment made to hospitals and SNFs generally cover all drugs provided during an inpatient stay.
- Part B
 - Most outpatient prescription drugs are not covered under Part B.
 - There are five major categories of drugs that are covered:
 - Physicians and drugs typically provided in physicians' offices.
 - Pharmacy suppliers and drugs administered through DME such as respiratory drugs given through a nebulizer.
 - Drugs billed by pharmacy suppliers and self-administered by the patient.
 - Separately billable drugs provided in Hospital Outpatient Departments.
 - Separately billable ESRD drugs such as erythropoietin (EPO).

Prescription Drug Event Data

- PDE data is a summary record submitted to CMS every time a beneficiary fills a prescription under Medicare Part D.
- PDE data should not be submitted to the EDS for processing.
- Only Part A and Part B drugs should be submitted to the EDS.

Overlapping EDS and PDE Data

Drug Type	EDS DRUG DATA	PDE Data
Oral Anticancer and Antiemetic Drugs	<ul style="list-style-type: none"> • If associated with cancer treatment. 	May cover in all other circumstances.
Vaccinations	<ul style="list-style-type: none"> • Influenza and pneumonia for all beneficiaries and Hepatitis B for medium and high risk beneficiaries. • Other immunizations only if beneficiary exposed to relevant disease. 	Required to provide coverage for many other vaccinations.
Insulin	<ul style="list-style-type: none"> • If dispensed by a pump. 	If injected with syringe.
Inhalants	<ul style="list-style-type: none"> • Drugs dispensed through nebulizers. 	Metered Dose Inhalers (MDIs).

Pharmacy Data Example

- On May 20, 2012, Mrs. Smith is given insulin by a pump by Dr. Jones. Dr. Jones submits the data to New Day Plan.

Question: How should this data be submitted to EDS?

1. Submit an 837-I
2. Submit an 837-P
3. Not acceptable for Encounter Data

Getting Started

All MAOs must:

- Enroll to submit encounter data.
- Complete encounter data testing requirements.

Submitter Requirements

All submitters must complete:

- An EDI Agreement.
- The Encounter Data Online Submitter Application.
- Additional forms.



Front-End System Testing

- **Submission Requirements:**
 - Daily submission cut-off time of 5:00 P.M. EST.
 - Submissions must include 50-100 encounters per transmission file.
 - One (1) institutional and one (1) professional test file must be submitted.
 - Mix of facility, professional, and DME required.
 - Acknowledgement reports will be provided within 24 hours of submission.

End-to-End Testing

- **Submission Requirements:**
 - Submissions must include 50-100 encounters per transmission file.
 - Mix of facility, professional, DME provider, chart review, and adjustment encounters required.

Certification

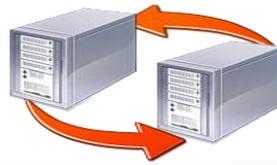
- Complete end-to-end testing.
- Receive 90% acceptance rate on file.
- Certification email delivered within 2 business days.

NOTE: Submitter level certifications

Connectivity

There are 3 connectivity application options:

- Gentran
- Network Data Mover (NDM)
- File Transfer Protocol (FTP)



Submission of Production Data

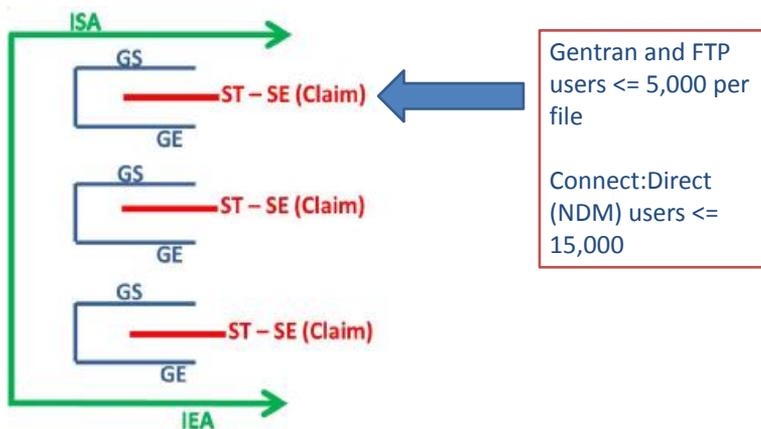
- Effective January 2012, submitters will be expected to submit 837-I and 837-P encounters according to CMS guidelines.
- Encounter data must be submitted within **13 months** of the claims' dates of service.



Submission Frequency

NUMBER OF MEDICARE ENROLLEES	MINIMUM SUBMISSION FREQUENCY
Greater than 100,000	Weekly
50,000 – 100,000	Bi-weekly
Less than 50,000	Monthly

File Size Limitations



Adjudicated Claims

TERM	ACCEPTABLE FOR EDS?
Accepted	YES
Denied	YES
Pending	NO
Rejected	NO

CMS wants finalized claims that have adjudicated in the MAO or other entity's claims processing system. In a capitated arrangement, this is still considered a finalized claim.

File Structure

- Encounter data must be submitted to the EDS on the **ANSI 837X V5010** format.
- Helpful Resources:
 - WPC Website
 - CMS Edits Spreadsheet
- Roles

WPC

Washington Publishing Company | EDI | HIPAA | XML - Windows Internet Explorer

http://www.wpc-edi.com/content/view/full/129/

WPC Complete Product List

Categories

If there are large number of products in a category, you can often refine your search by selecting a sub-category.

- Code Lists
- WPC 4010A1 to 5010 Change Description Guides
- WPC Software - Including JHM - Schemas
- WPC 4010A1 Combined HIPAA Guides
- ASC X12 Implementation Guides
- ASC X12 TR3 Schemas
- ASC X12 Table Data
- IMPACT Table Data
- Pharmacy Industry - Professional Claim Guide
- Rail Industry - Carriers Guide to EDI
- Ocean Industry - Ocean Carriers Guide to EDI

ASC X12 Implementation Guides

www.wpc-edi.com



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Submission

CMS Edits Spreadsheet

TechnicalDocumentation Medicare Fee-for-Service 5010 - D0 - Windows Internet Explorer

http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

10 CLM02-TOTAL-SUBMITTED-CHARGES PIC 99(8)V99.
10 CLM02-TOTAL-SUBMITTED-CHARGES-FILLER PIC X(8).

If alternative formats of the side-by-side comparison documents are needed, please use the "Submit Feedback" feature at the bottom of this page.

Downloads

- Professional Claim 837-P 4010A1 to 5010A1 Side by Side [PDF, 1,312KB]
- Institutional Claim 837-I 4010A1 to 5010A2 Side by Side [PDF, 1,572KB]
- Remittance 835 4010A1 to 5010A1 Side by Side [PDF, 336KB]
- Claim Status 276/277 4010A1 to 5010 Side by Side [PDF, 179KB]
- Eligibility 270/271 4010A1 to 5010A1 Side by Side [PDF, 761KB]
- NCPPP S.1 to D.D Side by Side [PDF, 288B]
- Excel formats - Professional, Institutional, NCPPP claims [ZIP, 356KB]
- Excel formats - Remittance, Claim Status Inquiry and Response, Eligibility Inquiry and Response [ZIP, 302KB]
- 5010 Institutional and Professional Edits spread sheets [ZIP, 3,155KB]
- 5010 Fee-for-Service Flat Files [ZIP, 482KB]
- 5010 Examples - 837, 835, TA1, 999, 277CA [ZIP, 265KB]

Related Links Inside CMS

There are no Related Links Inside CMS

Related Links Outside CMS

5010 Institutional and Professional Edits Spread Sheets

http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp



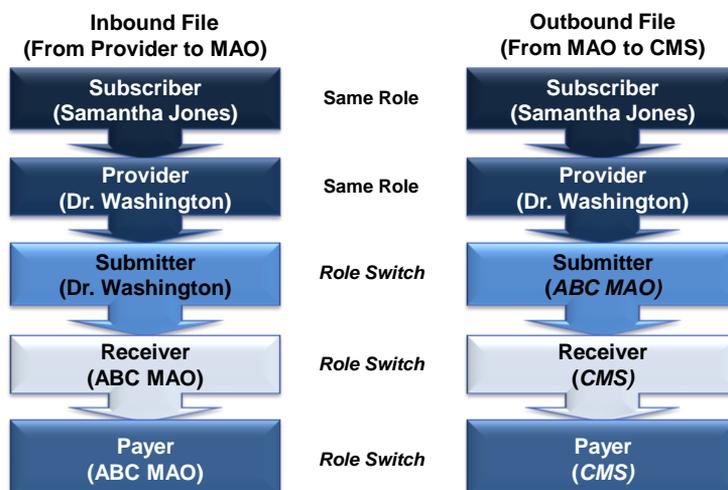
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Submission

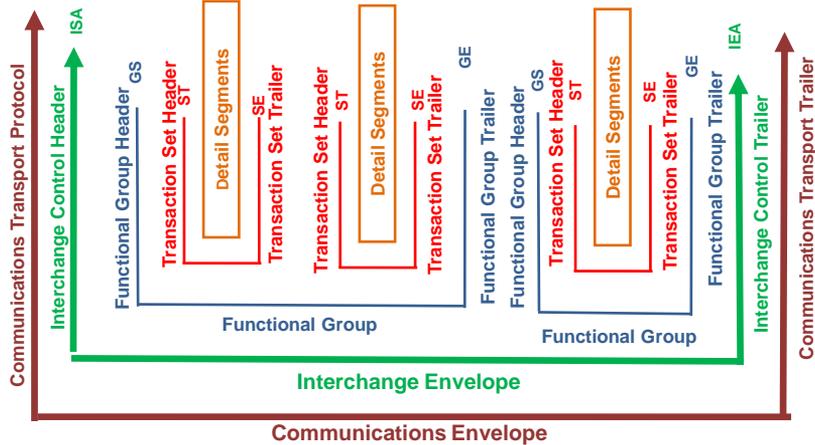
Roles

- There are a variety of roles during encounter data processing.
- Reformats must be made from the inbound to the outbound 5010 X12 837-I or 837-P file.
- For the outbound file, MAOs are considered the Submitter:
 - Loop ID-2000A = MAO Information.
 - Loop ID-2010BB (Payer Information) = CMS.

Example



Enveloping and Looping Structure



Loop Structure Example

- Example 1: The first segment in Loop 2010BB (Payer Name), is NM (Payer Name) and is required; therefore, the Loop is _____.
1. Not required.
 2. Required.
 3. Situational.

Loop Structure Example

- Example 2: The first segment in Loop 2000C (Patient Hierarchical Level) is HL (Patient Hierarchical Level) and is situational. It is populated only if the patient is different from the subscriber; therefore, the entire Loop 2000C is a _____.
1. Situational loop.
 2. Required loop.
 3. Not used.

Loop Structure Example

- Example 3: Loop 2300, segment HI (Admitting Diagnosis) is a situational field. If Loop 2300, segment HI is used, THEN HI01-1 and HI01-2 _____, as these are required data elements within the situational segment.
1. must not be used
 2. may be used
 3. must be used

Claim Submission Layout

- WPC loops categorized into three levels:
 - Header
 - Detail
 - Trailer

ISA – IEA

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
ISA01	Interchange Control Header	Identifies the type of information in ISA02	R
ISA02	Authorization Information	Information used for additional identification or authorization of the Interchange sender	R
ISA03	Security Information Qualifier	Identifies the type of information in ISA04	R
ISA04	Security Information	Information used to identify the security information about the Interchange sender	R
ISA05	Interchange ID Qualifier	“ZZ”	R
ISA06	Interchange Sender ID	MAO or Third Party Submitter ID (EN followed by Contract ID	R

*Note: this is not an all-inclusive list.

GS – GE

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
GS01	Functional Identifier Code	Two (2) character Functional Identifier Code assigned to each transaction set.	R
GS02	Application Sender's Code	MAO or Third Party Submitter ID (EN followed by Contract ID)	R
GS03	Application Receiver's Code	CMS Payer ID: 80881 – Institutional 80882 – Professional	R
GS04	Date	CCYYMMDD format	R
GS05	Time	HHMMSS format	R
GS06	Group Control Number	Must be identical to the control number in GE02	R
GS07	Responsible Agency Code	X – Accredited Standards Committee X12	R
GS08	Version/Release/Identifier Code	Transaction Version: <ul style="list-style-type: none"> 005010X223A2 – Institutional 005010X222A1 – Professional 	R
GE01	# of Transaction Sets Included	Total number of transaction sets included	R
GE02	Group Control #	Must be identical to the control number in GS06	R



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Submission

ST – SE

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
ST01	Transaction Set Identifier Code	837	R
ST02	Transaction Set Control Number	Must be identical to SE02	R
ST03	Implementation Convention Reference	Transaction Version: <ul style="list-style-type: none"> 005010X223A2 – Institutional 005010X222A1 – Professional 	R
SE01	Number of Included Segments	Must contain the actual number of segments within the ST-SE	R
SE02	Transaction Set Control Number	Must be identical to ST02	R



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Submission

Duplicates and Duplicate Logic

- Duplicate checking will occur at the:
 - File Level based on hash totals.
 - Claim Level based on demographic and specific claims data elements.

File Level Example

- On July 6, 2012, a submitted ISA – IEA interchange has a hash total of 800,000.
- On August 10, 2012, another ISA – IEA interchange is submitted with the exact same hash total of 800,000. *Is this a duplicate?*

Claim Level

- An encounter will be rejected as a duplicate if the following values match in the EODS*:
 - Beneficiary Demographic (HIC number, name)
 - Date of Service
 - Rendering Provider NPI
 - Procedure code
 - Place of Service (Professional only)
 - Type of Bill (Institutional only)

* This is a draft of the duplicate claim logic

Claim Level - Continued

Are there other values that should be added to the claim level duplicate check?

1. Modifier Codes
2. Payer Paid Amounts
3. Others

Chart Reviews

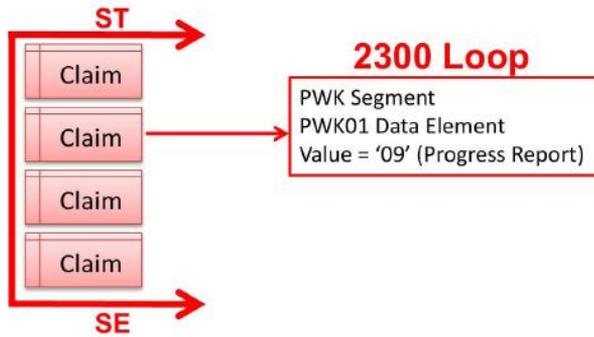
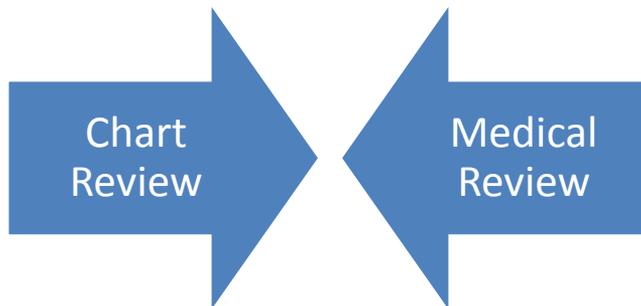


Chart Reviews



Linking Chart Review Data to an Original Encounter

Submitters must link chart review data submissions to the original encounter utilizing the ICN from the 277CA



Timing of Chart Review Data Submissions

Chart reviews must be submitted within 25 months of the beginning of the data collection period.



Interim Claims

- Interim claims may be submitted with the following values in the Claim Frequency Type Code, Loop 2300, CLM05-3:
 - “2”=Interim Bill – First Claim
 - “3”=Interim Bill – Continuous Claim
 - “4”=Interim Bill – Last Claim

Amount Fields

- Claim amount fields on the 837-I or 837-P must balance at the:
 - Claim level
 - Service line level

Claim Paid Amounts

- Total claim paid amounts must balance to:
 - The paid amounts on SV2 (Institutional)
AND
 - SV1 (Professional)
 - **LESS** any adjustments at the claim level reported in Loop 2320 and 2430

Claim Paid Amounts Example

- A claim has the following line level payments:
 - Line 1 Charge - \$80.00 (SV101 or SV201)
 - Line 1 Payment - \$70.00 (SVD2)
 - Line 2 Charge - \$20.00 (SV101 or SV201)
 - Line 2 Payment - \$15.00 (SVD2)
- Paid amounts are populated at the line level

Atypical Providers

- Providers who are not considered health care providers and do not provide health care services.
- Examples:
 - Non-emergency transportation providers
 - Personal Care Attendants
 - Building Contractors
 - Language Interpreters

Atypical Providers (*cont.*)

- All entities that do not meet the HIPAA definition of “health care provider” per the Code of Federal Regulations (45 CFR 160.103) are ineligible to obtain an NPI.
- If the entity or individual meets the definition of **Health care provider**, then they are eligible for an NPI.

Default NPI

- CMS is currently developing editing logic for submission of encounter data from atypical provider types.
- Atypical providers will be issued a default NPI for encounter data submission.
 - Payer ID 80881 (Institutional) – 7777777773
 - Payer ID 80882 (Professional) – 8888888889

Submitting Data from Capitated Providers

- Capitated and staff model arrangements must populate and submit valid CPT codes on 5010.
- “0.00” should be populated in amount fields where no amount information is available.
- Capitated claims submitted with “0.00” in the amount fields will be priced according to 100% of the Medicare allowable amount.

Flagging Capitated Encounters

To indicate the encounter data submission is from a capitated provider, MAOs and other entities must...

- Populate Loop ID-2400, segment CN1, data element CN101 with a value of “05” for each capitated service line if there is a mix of capitated and non-capitated service lines (for professional only).



Examples

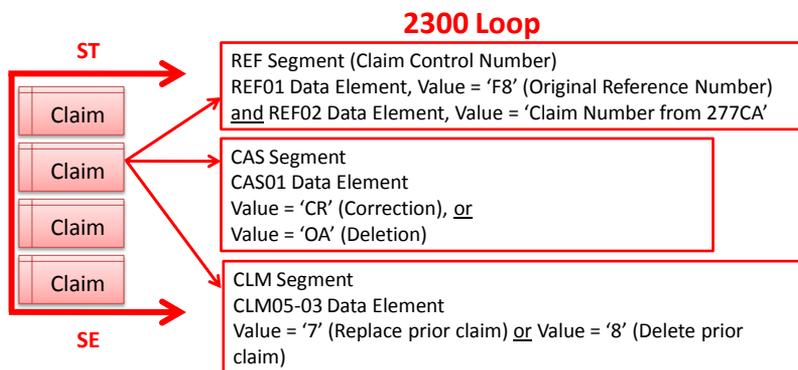
- MetroPlan has a capitated arrangement with Dr. Smith. All service lines of the encounter are capitated. In order for MetroPlan to submit Dr. Smith’s claim to EDS, the plan must submit a file using Loop 2400 for each service line, data element CN101 and enter a value of _____.
- MetroPlan will populate “0.00” in CLM02.
 1. “MetroPlan”
 2. “C-05”
 3. “05”

Special Considerations for Cost Plans

- The Social Security Act (the Act) stipulates that cost plans are required to submit encounter data.
- CMS required Cost Plans to submit diagnostic data for dates of service after July 1, 2004.



Adjustments



EDS Repurposed Adjustment Values

LOOP	DATA ELEMENT	VALUE	X12 5010 STANDARD	EDS USAGE
2320	CAS01	CR	Correction and Reversals	Correction
2320	CAS01	OA	Other Adjustment	Deletion

Deletions

- Loop 2320, segment CAS, data element CAS01=OA (Deletion) allows deletion of previously submitted encounter data.
- A deletion indicator ('OA') is submitted to delete an entire claim.



Deletion Example

- Urban Care Plan determines that they mistakenly sent a claim that was not adjudicated.

In order delete the entire claim, the plan will:

1. Submit an 837 claim using F8 in the 2300 along with “OA” in the CAS segment and a value of “8” in the CLM05-03 element
2. Call the 1-800-helpline.
3. Hit the delete button.

Correction

- Loop 2320, segment CAS, data element CAS01 = CR (Correction) overwrites submitted encounter and replaces previously submitted data.
- An adjustment indicator ('CR') within CAS segment can only be used within 2300 level loop.
- Line level corrections (2400 level loop) cannot be processed for encounter data purposes.

Adjustments

Happy Health Plan submits encounter A and receives an ICN. They determine that encounter A needs to be replaced, so they submit an adjustment to replace encounter A with encounter B, using the ICN of encounter A. Happy Health Plan receives the ICN for encounter B. Happy Health Plan determines they need to adjust encounter B. Using the ICN of encounter B, Happy Health Plan submits an adjustment, which replaces encounter B with encounter C. Which of the encounters shows the final picture?

1. Encounter A
2. Encounter B
3. Encounter C

Encounter Data Pricing

- Pricing occurs in EDPS sub-systems and includes:
 - Institutional (EDIPPS)
 - Professional (EDPPPS)
 - DME (EDDPPS)

Filtering Logic

- Submitters are responsible for submitting data from all data sources to the EDS.
- Acceptable risk adjustment sources will be used to calculate the risk score in the risk adjustment payment.
- Filtering process will be applied to identify the data that used to calculate the risk score.

Institutional Filtering Logic

- For institutional services, the filtering logic is based on TOB.
- Refer to Table 2E1 in the Participant Guide.

Professional Filtering Logic

- For professional services, the filtering logic is based on the NPI, and specialty code indicator.

Encounter Data Service	Specialty Code	Crosswalk to Risk Adjustment Source of Data	Payment in Risk Adjustment	Translator Processing	Encounter Data Processing System	Pricing
General Practitioner	01	**See Acceptable Physician Specialty List	Yes	CEM	EDPPPS	MPFS

Acceptable Physician Specialties

- Professional data requires a face-to-face visit with professionals listed on the CMS specialty list.
- All professional data must be submitted to EDS.
- Only those acceptable physician specialties will be used for risk adjustment payment determination.

Summary

- Described acceptable sources of data.
- Explained the submission process requirements, connectivity options, and EDS file layout.
- Applied HIPAA transaction standards for purposes of encounter data collection.
- Identified risk adjustment filtering logic.

Evaluation



Please take a moment to complete the evaluation form for the Submission of Encounter Data module.

Your Feedback is Important! Thank you!



2011 Regional IT Technical Assistance Encounter Data



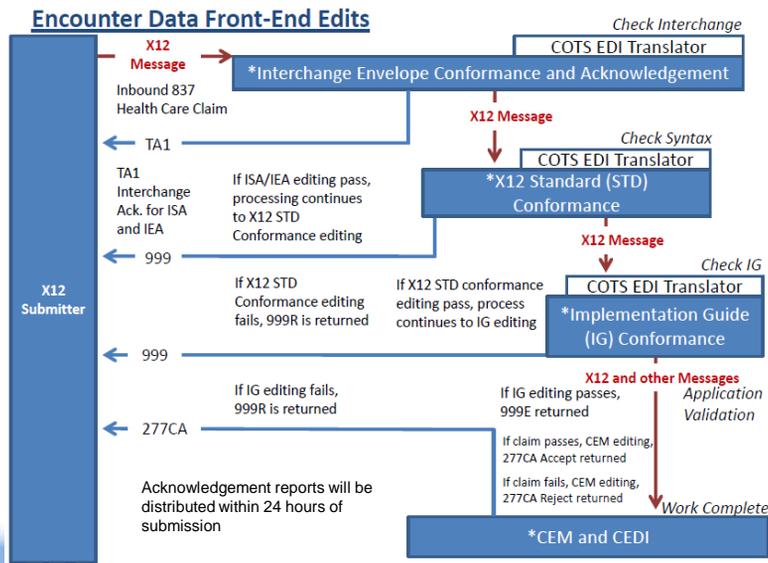
Purpose

- Introduce participants to the Encounter Data Front-End System (EDFES) acknowledgment reports.
- Provide insight on the appropriate use of the reports to manage data submission and error resolution processes.

Learning Objectives

- Interpret EDFES acknowledgement reports.
- Describe the Encounter Data System (EDS) error codes.
- Identify Common Edits and Enhancement Modules (CEM) edits applied within EDS.

Data Flow



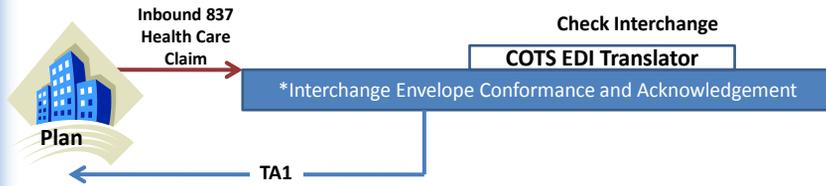
Naming Convention

CONNECTIVITY METHOD	TESTING NAMING CONVENTION	PRODUCTION NAMING CONVENTION
GENTRAN	GUID.RACF.EDS.FREQ.CCCCC.FUTURE.T	GUID.RACF.EDS.FREQ.CCCCC.FUTURE.P
NDM	MAB.PROD.NDM.EDST.TEST.ENXXXXX (+1)	MAB.PROD.NDM.EDST.PROD.ENXXXXX(+1)
FTP	User Defined	User Defined

TA1 Acknowledgement Report

- Data submitted through EDFES is received following submission.
- Interchange rejected.
- Acknowledges status of submission.

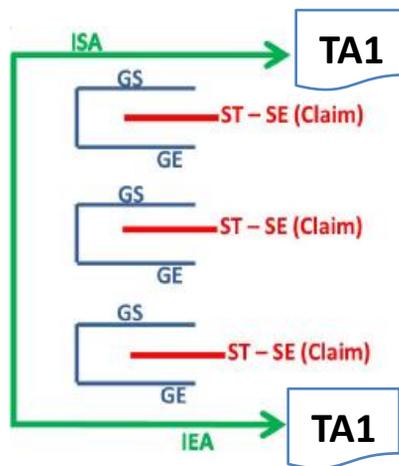
TA1 Acknowledgement Report



TA1 includes interchange:

- Control Number
- Date and Time
- Acknowledgement Code
 - R = Rejected
- Note Codes

Interpreting the TA1



Scenario

Apple Health Plan received a TA1 acknowledgement indicating the interchange was rejected due to an Invalid Interchange ID for the Sender. The TA104 data element indicates the interchange was rejected, as shown by an “R.” The TA105 data element indicates an interchange note code of “006,” which means the interchange was rejected due to an Invalid Interchange Sender ID.

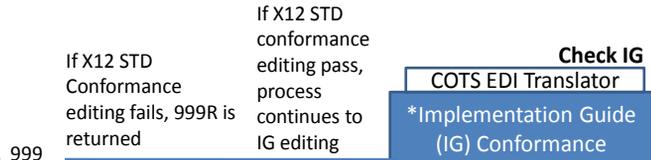
TA1 Snapshot Report

```
ISA*00      *00      *ZZ*80883      *ZZ*      ENH1234*  
110905*1701*^*00501*900000001*0*T::~~  
TA1*900000001*110905*1700*R*006~  
IEA*0*900000001~
```

Acknowledgement Code “R” populated in field 22 indicates rejected file

Interchange Note Code “006” populated in field 23, indicates an Invalid Interchange Sender ID

999 Acknowledgement Report



- Validates GS/GE Functional Groups
- Implementation Guide (IG) Edits
- Functional Group
 - Accepted or Rejected

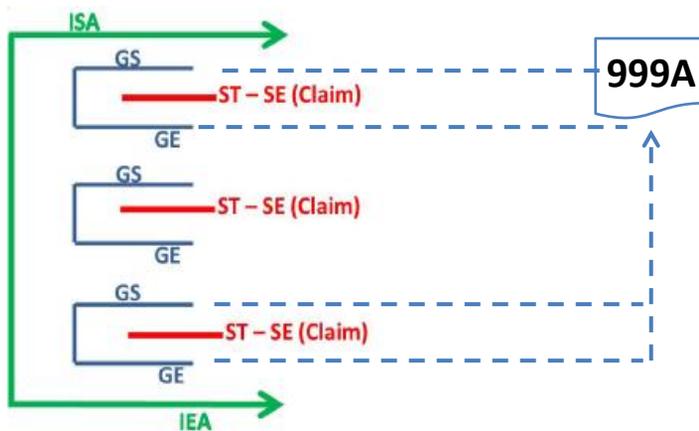
999 Acknowledgement Report

- Three possible acknowledgement values can be populated in the response:
 - A – Accepted
 - 999A response report produced
 - R – Rejected
 - 999R response report produced
 - E – Accept with Errors
 - 999E response report produced

999A Acknowledgement Report

- Functional Groups accepted.
- No further action required, processing continues to Common Edits and Enhancement Module (CEM).
- No associated note or error code present.

999A Interpretation



999A Sample Report

```
ISA*00* 00* ZZ* ENX1234*ZZ*
80881*100831*1425*00501*^* 243013828*0*T::~
GS*FA*80881*ENX1234*20100831*1425*243013832*X*005010X231~
ST*999*0001*005010X231~
AKI*HC*1111*005010X223A2~
AK2*837*111111111*005010X223A2~
IK5*A~
AK9*A*1*1*1~
SE*6*0001~
GE*1*243013832~
IEA*1*243013828~
```

Field (22) is IK5 indicates Transaction Set Response Trailer
Field (23) is IK501 indicates Transaction Set Acknowledgement Code, "A" = Accepted

Field (24) is AK9 indicates Functional Group Response Trailer
Field (25) is AK901 indicates Functional Group Acknowledgement Code, "A" = Accepted

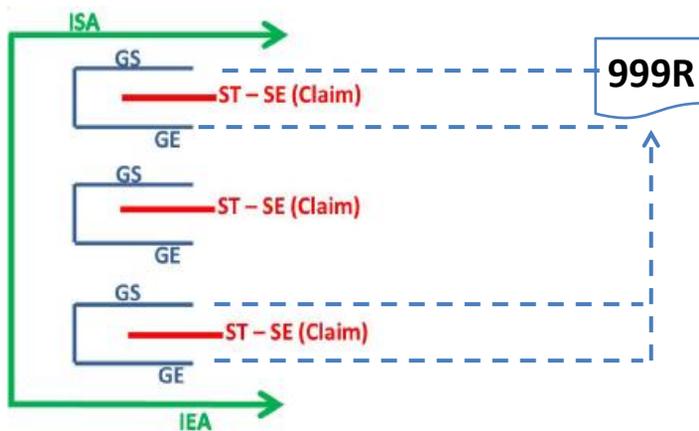
Scenario

The 999A acknowledgement report showing an acceptance of the file and contains one (1) GS/GE; however, there may be multiple GS/GE functional groups within a file.

999R Acknowledgement Report

- Reflect errors on functional group level.
- X12 functional group to be rejected.
- Correct and resubmit.
- Fields:
 - IK5 – Transaction Set Response Trailer
 - AK9 – Functional Group Response Trailer

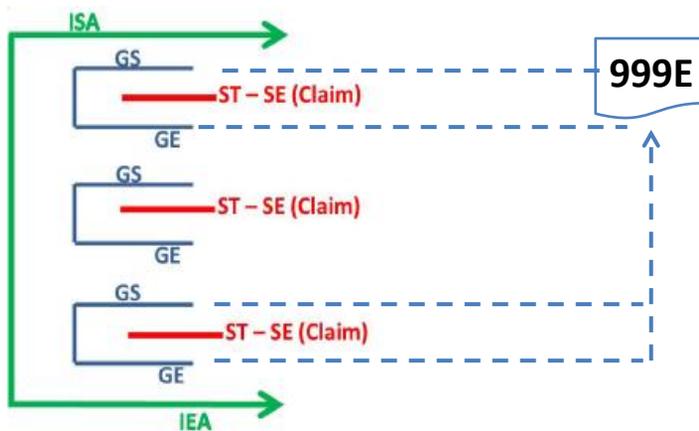
999R Interpretation



999E Acknowledgement Report

- Reflects that the translator recognized an error, but the error is not significant to cause file rejection.
- X12 functional group accepted with non-syntactical errors and forwarded for processing.

999E Interpretation



Scenario

Mercy Health Plan submits an interchange file to the EDS and receives a 999E report indicating the transactions were accepted with errors. Mercy Health Plan populated the 837-I with NM107 data element (Name Suffix, WPC data element location 1039), with JUNIOR. The 999E report notifies Mercy Health Plan that there was a data element in error, specifically that there was an invalid character in data element NM107.

Claim Acknowledgement Transaction (277CA) Report



← 277CA

If claim passes, CEM editing, 277CA Accept returned

If claim fails, CEM editing, 277CA Reject returned

Work Complete

*CEM and CEDI

- Third level of editing
- Checks validity of values within data elements
- Unsolicited response
- Returned within 24 hours of submission

277CA Acknowledgement

- Resubmit rejected claims.
- Accepted claim provides the ICN assigned to the claim.
 - REF segment,
 - REF01=IK and
 - REF02=ICN (unique 13-digit number)

277CA Interpretation



Claim Level

- Edits on STC segment
- STC01 – Acknowledgement code
- STC02 Claim status
- STC03
 - WQ – Accepted
 - U – Rejected
- Claim level edits

277CA Scenario

```
ST*277*0001*005010X214~  
BHT*0085*08*277X21400001*20110805*1635*TH~  
HL*1**20*1~  
NM1*PR*2*EDSCMS*****46*80881~  
TRN*1*200102051635500001ABCDEF~  
DTP*050*D8*20110805~  
DTP*009*D8*20110805~  
HL*2*1*21*1~  
NM1*41*2*ABC MAO*****46*ENH1234~  
TRN*2*2002020542857~  
STC*A7:23*20110805*U*1000~  
QTY*AA*3~  
AMT*YY*1000.00  
HL*3*2*19*0~  
NM1*85*2*SMITH CLINIC*****FI*123456789~  
TRN*1*SMITH789~  
STC*A7:511:85**U*1000.00*****A7:504  
QTY*QC*3  
AMT*YY*1000.00  
SE*22*0001~
```

277CA Scenario - Continued

1. What is the value indicated on the STC segment for the Claim Status Category Code (CSCC)?
2. Why did the encounter reject?

Scenario

What are the associated CSCC and Claim Status Code (CSC) with the rejected claims? What are the ICN numbers for the accepted claims?

Summary

- Interpreted EDFES acknowledgement reports.
- Described the Encounter Data System (EDS) error codes.
- Identified Common Edits and Enhancement Modules (CEM) edits applied within EDS.

Evaluation



Please take a moment to complete the evaluation form for the Reports module.

Your Feedback is Important! Thank you!



2011 Regional IT Technical Assistance Encounter Data



Purpose

- Provide the compliance standards for encounter data collection.
- Establish preliminary enforcement mechanisms for encounter data collection and submission

Learning Objectives

- Describe HIPAA standards related to encounter data.
- Identify the encounter data compliance standards.
- Understand the enforcement of encounter data compliance measures.

HIPAA Standards

- Improve continuity of care.
- Combat waste, fraud, and abuse.
- Improve access to care.
- Simplify the administration of health insurance.

5010 Standard Format

- Effective January 1, 2012, all health care claims must be submitted electronically using the ANSI X12 V5010.
 - Professional data – Errata for ASC X12N 837/005010X222A1.
 - Institutional data – Errata for ASC X12N 837/005010X223A2.

Enforcement of Format Standards

- Failure to comply will result in the following:
 - Data will be rejected and returned to the submitter for correction.
 - Risk adjustment payment will be adversely affected beyond the 2012 data collection year.

Encounter Data Compliance Standards

- Compliance standards will be monitored per contract ID in these areas:
 - Timeliness of submission.
 - Quantity (volume) of submission.
 - Quality of submission.
 - Accuracy of submission

Timeliness of Submission

- Submission of adjudicated claims data
 - 13 months from date of service
 - 60% within 60 days from date of service
 - 90% within 90 days from date of service
- Submission of chart review data.
 - Follows the existing RAPS timeframe.

Timeliness of Submission

- Submission prior to the last day of required reporting period.
 - Staggered submission.
- Submission of adjustment data (draft policy)
 - Within 30 days of the adjudication date for the correction and/or modification

Submission Frequency

NUMBER OF MEDICARE ENROLLEES	MINIMUM SUBMISSION FREQUENCY
Greater than 100,000	Weekly
50,000 – 100,000	Bi-weekly
Less than 50,000	Monthly

Enforcement of Timeliness Standards

- Non-compliance results in submissions being rejected.
- CMS will communicate additional measures as appropriate.

Quantity of Submission

- Volume of files submitted must align with a number of metrics based on FFS benchmarks.
- Metrics may include:
 - Submission rates.
 - Proportions of claims in select service categories, and
 - Overall volume of submission.

Enforcement of Quantity Standards

- CMS will apply the FFS benchmarks to compliance rates
- Benchmarks may be adjusted over time as MA encounter data is baselined
- May impact plan payment.
- Procedures for non-compliance will be developed which will feed into the CMS compliance framework.

Quality of Submission

- All submitters must collect and submit encounter data in the 5010 format.
- Comply with federal standards for encryption, data transmission, security, and privacy
- Quality metrics will include at a minimum:
 - Do not exceed 5% error rate
 - Duplicate encounters.

Accuracy of Submission

- CMS will audit submitted claims back to the MA organization and other entities' claims system.
- Encounters should link back to original claims/verifiable electronic transactions and/or paper claims and be unmodified from the original claim.
- Adjudication processes may be applied but no alternation of original claims will be accepted especially in relation to HCPCS/Revenue codes/Diagnosis data

Enforcement of Quality and Accuracy Standards

- Failure to comply will result in CMS action, which may include a letter of non-compliance.
- Compliance activities for encounter data will be coordinated with CMS compliance policies and procedures.
- CMS to communicate additional measures in the future.

Summary

- Described HIPAA standards related to encounter data.
- Identified the encounter data compliance standards.
- Understood the enforcement of encounter data compliance measures.

Evaluation



Please take a moment to complete the evaluation form for the Compliance module.

Your Feedback is Important! Thank you!

Transition to the Encounter Data System



2011 Regional IT Technical Assistance Encounter Data



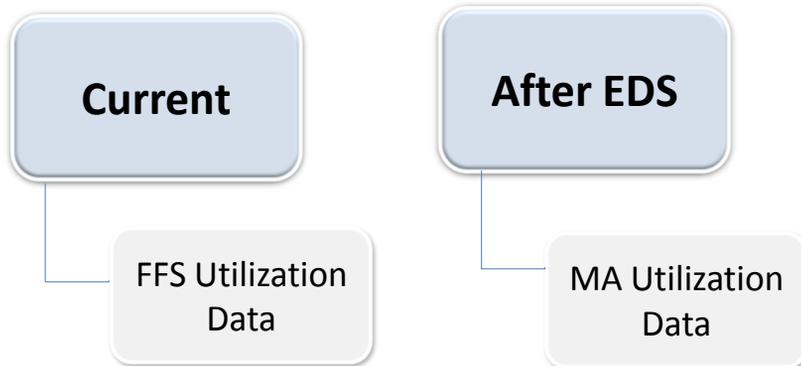
Purpose

- To provide operational guidance to the industry on the transition process from Risk Adjustment Processing System (RAPS) to Encounter Data System (EDS).

Learning Objectives

- Describe the implementation plan to run parallel systems.
- Identify the target roll-out dates for phase-in of the EDS and phase out of RAPS.
- Discuss the expectations for reconciliation during the transition to EDS.

Risk Adjustment Model Calibration



Parallel Systems Processing

- The purpose of Parallel Systems Processing is to:
 - Ensure EDS functionality.
 - Validate accuracy and quality of encounter data collected.

Target Timeline

- The timeline for transition to the EDS will include:
 - RAPS and EDS running in parallel for a minimum of one (1) year.
 - CMS validation of EDS functionality and accuracy.
 - Cessation of RAPS submission.

Phase-In of the EDS

- Phase-in of the EDS will occur in two (2) parts:
 - Testing of the Encounter Data Front-End System (EDFES).
 - Testing of the Encounter Data Processing System (EDPS).

Testing of the Encounter Data Processing and Pricing System

EDS IMPLEMENTATION TIMELINE		
START DATE	END DATE	EVENT
March 30, 2011	September 05, 2011	Test Case Preparation Period
September 06, 2011	October 04, 2011	Front-End Testing
October 05, 2011	October 28, 2011	Encounter Data Processing System Test Case Preparation and Education
October 31, 2011	November 30, 2011	Encounter Data System Institutional and Professional Testing/certification
January 3, 2012	January 3, 2012	Encounter Data Institutional and Professional roll-out

Durable Medical Equipment Processing and Pricing System

ENCOUNTER DATA DME PROCESSING TESTING	
DATE	EVENT
February 06, 2012	MAO front-end testing of Encounter Data DME CEDI module and Encounter Data DME Processing and Pricing system begins.
May 07, 2012	Encounter Data DME Processing and Pricing system roll-out.

Roll-out of EDIPPS and EDPPPS

✘ January 3, 2012



Implementation Timeline for PACE

PACE IMPLEMENTATION TIMELINE		
EVENT	START DATE	END DATE
Execute Encounter Data Pilot Test for PACE plans	February 15, 2012	February 28, 2012
Completion of the EDI Agreement and Submitter ID Application	March 30, 2012	June 30, 2012
Execute EDFES Testing	March 30, 2012	June 30, 2012
Execute EDIPPS and EDPPPS Sub-system End-to-End Testing	July 18, 2012	September 30, 2012
Encounter Data PACE plans roll-out	January 3, 2013	N/A

Phase Out of RAPS

- Parallel processing begins January 3, 2012.
- Data should be submitted to RAPS and EDS for at least 1 year.
- To phase out, the goal is to have no impact to plan payments.

RAPS Phase-Out Schedule

PY	SUBMISSION DEADLINE	PAYMENT	RISK SCORE AND BENCHMARKING
2013	09/2012	Initial 01/2013	RAPS Risk Score EDS Benchmarking
	03/2013	Mid-Year 07/2013	RAPS Risk Score EDS Benchmarking
	01/2014	Reconciliation 08/2014	RAPS Risk Score EDS Benchmarking
2014	09/2013	Initial 01/2014	EDS Risk Score/RAPS
	03/2014	Mid-Year 07/2014	EDS Risk Score
	01/2015	Reconciliation 08/2015	EDS Risk Score
2015	09/2014	Initial 01/2015	EDS Risk Score
	03/2015	Mid-Year 07/2015	EDS Risk Score
	01/2016	Reconciliation 08/2016	EDS Risk Score

PY 2013 Example

For payment year 2013, Plan A submits a claim from February 2012 by February 2013 (within 13 months from the date of service) and prior to the March 2013 deadline. If the diagnosis is in the model, it will be reflected in a RAPS risk score and be used by CMS for Encounter Data Benchmarking. The RAPS risk score will appear as the July 2013 Mid-Year risk score.

PY 2014 Example

For payment year 2014, Plan B submits a claim from January 2013 (the earliest possible submission month for a claim to count towards an Encounter Data risk score). Since plans have up to 13 months to submit the claim from the date of service, the claim must be submitted no later than January 2014. This claim would be captured for 2014 Mid-Year payment and be reflected in the Mid-Year risk score as an Encounter Data risk score.

PY 2014 Example

For payment year 2014, Plan C has a claim to submit from December 2013. Since plans have up to 13 months to submit the claim from the date of service, the claim must be submitted no later than January 2015. This data would be captured for 2014 final payment and reflected in the final reconciliation risk score as an Encounter Data risk score.

2012 Submission Expectations

- Submit claims data to both RAPS and EDS.
- Comply with submission requirements of both RAPS and EDS.
- Payment is based on RAPS data.

2012 Payment Reconciliation

- For 2012:
 - Based on RAPS submissions.
 - Conducted with RAPS reports.
 - EDS reports used to ensure data elements are captured and to project risk scores.

Summary of First Year Expectations

Expectations for Transition to EDS	
2012	2013
<ul style="list-style-type: none">• MAOs and other entities submit to RAPS and EDS.• MAOs and other entities must comply with submission requirements of RAPS and EDS.• Payment calculations and reconciliation based upon submission to RAPS.• MAOs and other entities should follow the RAPS submission deadlines and sweep schedule for payment reconciliation.	<ul style="list-style-type: none">• Further information on expectations for 2013 payment year will be released at a later date.

Resources for Systems Transition to EDS

- X12 Version 5010 Standards:
http://www.cms.gov/Versions5010andD0/01_overview.asp
- Proposed 5010 Institutional (837-I) and Professional (837-P) CEM and 5010 format crosswalks:
http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

Resources for Systems Transition to EDS

- TA1, 999, 277CA Report Formats:
https://www.cms.gov/Versions5010andD0/downloads/Acknowledgements_National_Presentation_9-29-10_final.pdf
- The Washington Publishing Company (WPC) provides the full view of elements required for the Version 5010:
<http://www.wpc-edi.com/content/view/817/1>

Summary

- RAPS and EDS will run parallel to mitigate risk to plan payments during transition to EDS.
- MAOs and other entities will continue to submit data to RAPS for at least the 2012 payment year.
- Once CMS validates EDS, RAPS will cease and submission and payment reconciliation will occur through EDS only.

Evaluation



Please take a moment to complete the evaluation form for the Transition to the Encounter Data System module.

Your Feedback is Important! Thank you!